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THE SOCIAL CONTEXT OF ONCOFERTILITY

Dorothy E. Roberts*

INTRODUCTION

As more women survive cancer, researchers are developing technologies that enable these women to become mothers despite the toll the disease and its treatment can have on their fertility. A field known as oncofertility provides female cancer patients with a variety of ways to preserve their fertility so that they may bear genetically related children after successful cancer treatment.¹ Some women delay cancer therapy so doctors can collect their eggs, which are then cryopreserved in an unfertilized state or used to create embryos through in vitro fertilization (IVF) for freezing.² When women are healthy again, they can become pregnant by implanting their stored embryos or the embryos created from their frozen eggs. An experimental procedure for preserving the fertility of prepubertal girls, known as ovarian tissue cryopreservation, involves surgically removing their ovarian tissue and growing the immature eggs to a mature state so they can be frozen and stored until the girls are old enough to bear a child.³

* Kirkland & Ellis Professor, Northwestern University School of Law; faculty fellow, Institute for Policy Research. This Article is based on my keynote address at the Twenty-first Annual DePaul Law Review Symposium, *Changing Conceptions: Exploring the Medical and Legal Advances in Fertility Preservation*, on March 11, 2011. I thank Teresa Woodruff, Director of the Northwestern Oncofertility Consortium, for inviting me to participate in the Consortium and for her comments on my presentation at the 2011 Oncofertility Consortium Conference. Thanks also to Mary Anne Case and participants at the Regulation of Family, Sex, and Gender Workshop at University of Chicago School of Law and to colleagues at a Northwestern University School of Law faculty workshop for their comments on a draft of this Article. I am also grateful to Caroline Goldstein, Marcia Lehr, and Alexius O'Malley for excellent research assistance, and to the Kirkland & Ellis Fund and the Dorothy Ann and Clarence L. Ver Steeg Distinguished Research Fellowship for research support.

1. See generally ONCOFERTILITY: ETHICAL, LEGAL, SOCIAL, AND MEDICAL PERSPECTIVES (Teresa K. Woodruff et al. eds., 2010); Gwendolyn P. Quinn et al., *Frozen Hope: Fertility Preservation for Women with Cancer*, 55 J. MIDWIFERY & WOMEN'S HEALTH 175 (2010); Amanda J. Redig et al., Commentary, *Incorporating Fertility Preservation into the Care of Young Oncology Patients*, CANCER, Jan. 1, 2011, at 4.

2. Susan C. Klock et al., *Fertility Preservation for Female Cancer Patients: Early Clinical Experience*, 94 FERTILITY & STERILITY 149 (2010); Audra D. Robertson et al., *Embryo Yield After In Vitro Fertilization in Women Undergoing Embryo Banking for Fertility Preservation Before Chemotherapy*, 95 FERTILITY & STERILITY 588 (2011).

3. Cynthia B. Cohen, *Ethical Issues Regarding Fertility Preservation in Adolescents and Children*, 53 PEDIATRIC BLOOD & CANCER 249 (2009); Gregory Dolin et al., *Medical Hope, Legal*

Ethical questions raised by fertility preservation are not confined to the clinic and bedside; rather, these questions extend to the impact of fertility preservation on society and the way social forces influence women's decisions about their fertility. Discussions about the ethics of preserving the fertility of women and girls who survive cancer must take into account the fact that reproductive decision making occurs in a social context. Gender, class, and race inequities help determine the reproductive options available to women, such as a woman's access to assisted reproductive technology (ART), and the consequences that a woman's childbearing decisions have for her, her family, and her community. This social context is important despite the distinction some scholars make between "medical" and "social" reasons for freezing eggs, distinguishing infertility caused by disease or treatments for disease from infertility caused by delaying childbearing.⁴ Although oncofertility procedures respond to a medical need, "disease-related egg freezing" operates in a social context as much as "age-related egg freezing" does.⁵

Similarly, scientific innovations such as fertility-preserving technologies are not neutral tools that have a pre-determined intrinsic value. Rather, their use is shaped by their interaction with ideologies and structures of power, including hierarchies of race, class, and gender, and related social views. But this is not a unidirectional effect of society-influencing technology: new forms of science and power emerge *simultaneously*.⁶ The uses and outcomes of novel technologies like oncofertility are determined by their social context at the same time that these technologies have an impact on society. Fertility preservation has the power to reinforce or subvert social structures and norms marked by gender, race, class, and other inequities.

There is a public as well as personal stake in policies regarding fertility preservation. Procreation's special status stems as much from its role in social structure and political relations as from its significance to

Pitfalls: Potential Legal Issues in the Emerging Field of Oncofertility, in ONCOFERTILITY: ETHICAL, LEGAL, SOCIAL, AND MEDICAL PERSPECTIVES, *supra* note 1, at 111, 123; Catherine Poirot & Benoit Shubert, *Fertility Preservation in Prepubertal Children*, 98 BULL. CANCER 489 (2011).

4. See NAOMI R. CAHN, TEST TUBE FAMILIES: WHY THE FERTILITY MARKET NEEDS LEGAL REGULATION 134-35 (2009) (distinguishing between medical, structural, and cultural infertility); Angel Petropanagos, *Reproductive 'Choice' and Egg Freezing*, in ONCOFERTILITY: ETHICAL, LEGAL, SOCIAL, AND MEDICAL PERSPECTIVES, *supra* note 1, at 223, 224. As I discuss in Part IV, this dichotomy typically omits the social reasons why African-American women disproportionately suffer from medical infertility as well as the way incarceration disproportionately compels them to delay childbearing. See *infra* notes 87-89 and accompanying text.

5. Petropanagos, *supra* note 4, at 224 (emphasis omitted).

6. See generally JENNY REARDON, RACE TO THE FINISH: IDENTITY AND GOVERNANCE IN AN AGE OF GENOMICS (2005).

individuals.⁷ Women of color who advocate for reproductive justice distinguish between traditional notions of reproductive choice that center on freedom from state interference in an individual woman's procreative decisions and a more politically conscious approach that places procreative decision making in its social context.⁸ A reproductive justice framework examines how inequities based on systems of power create barriers to reproductive freedom, forming a reproductive hierarchy in which some women's childbearing is valued more than others'. This approach acknowledges the justice of ensuring equal access to family planning without denying the injustice of imposing contraception as a means of population control and a solution to social problems. Reproductive justice advocates treat the legal fight for reproductive freedom as part of a larger struggle to create a more egalitarian society.

Because it is unethical for the government to limit childbearing by socially disadvantaged women in order to improve society, state provision of family planning must be contingent on improvements in general health and living conditions. Eugenic policies aimed at reducing the births of socially devalued groups perpetuate the myth that disparities in wealth, health, and education are caused by the victims of inequitable social structures. At the same time, once those seeking high-tech fertility preservation ask the government to devote public funds or mandate private spending to support their reproductive decisions, the public may evaluate the social costs and benefits of investing in these technologies not only for individual patients, but also for the broader society. Does state investment in oncofertility research and procedures constitute a just distribution of public resources?

Considering the role social context plays in the ethics of fertility preservation reveals several paradoxical tensions that policy makers will have to resolve. First, on one hand, oncofertility promotes gender equity by providing female cancer patients the opportunity to bear a child and by placing them on equal footing with their male counterparts. On the other hand, oncofertility may help to reinforce the gender-biased assumption that all women should become mothers, ideally by bearing children who are genetically related to them. Second, expanding private insurance coverage of oncofertility procedures will help to extend access to women who cannot afford to pay for

7. See generally DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 294–312 (1997); RICKIE SOLINGER, *PREGNANCY AND POWER: A SHORT HISTORY OF REPRODUCTIVE POLITICS IN AMERICA* (2005).

8. See generally ROBERTS, *supra* note 7; JAE SILLIMAN ET AL., *UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE* (2004).

them. Yet it may also increase gaps in access to ART by privileging those who are already the most economically advantaged. In addition, while subsidizing oncofertility may give women of color greater access to high-tech medical care, such subsidies may mask deeper inequities that produce racial disparities in reproductive health.

II. GENDER INEQUALITY AND REPRODUCTIVE DECISIONS

Does oncofertility promote gender equality by giving female cancer patients the reproductive options men have, or does it reinforce “repronormativity” by fulfilling the expectation that all women will become mothers?⁹ A key objective of oncofertility research is to give women undergoing cancer treatment the means to fulfill their desire to bear a child. The procedure expands the reproductive options these women have, allowing them to choose whether or not to have a child despite experiencing fertility loss as a result of cancer. Megan Faurot and Teresa Woodruff, Director of the Northwestern Oncofertility Consortium (Consortium) and a leading pioneer in the field, describe the “driving force” of the university initiative as “[s]upporting the oncofertility patient decision-making process with improved preservation options.”¹⁰ Thus, oncofertility furthers a hallmark of women’s liberation during the last century—women’s ability to make decisions about their childbearing.¹¹ According to this view, it expands the range of women’s choices rather than influencing what their choices should be.

Fertility preservation places women on equal footing with men, who can more easily safeguard their ability to have genetically related children by collecting and storing their sperm. Woodruff focuses on this aspect of gender equity in explaining the original mission of the Consortium, noting that prior to the development of oncofertility procedures, “[w]omen had the same hope for survival as men but fewer reproductive options.”¹² This observation reflects the gender-equalizing function of egg freezing outside the context of cancer. As

9. See generally Katherine M. Franke, Essay, *Theorizing Yes: An Essay on Feminism, Law, and Desire*, 101 COLUM. L. REV. 181 (2001).

10. Megan Faurot & Teresa K. Woodruff, *The Oncofertility Saturday Academy: A Paradigm to Expand the Educational Opportunities and Ambitions of High School Girls*, in ONCOFERTILITY: ETHICAL, LEGAL, SOCIAL, AND MEDICAL PERSPECTIVES, *supra* note 1, at 321, 321.

11. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (recognizing the right of women to choose to have an abortion before viability); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261 (1992).

12. Teresa Woodruff, Opening Address at the Northwestern Oncofertility Consortium Annual Conference: Oncofertility: Five Years Ago, Five Years Ahead (Sept. 12, 2011), available at <http://oncofertility.northwestern.edu/media/oncofertility-five-years-ago-five-years-ahead>.

Adrienne Asch notes, "Egg-freezing might lessen women's sense of having a 'biological clock,' and could give them some of the freedom men have always enjoyed about whether and when to reproduce."¹³

Proponents of oncofertility recognize that many women want to become mothers and suffer when they are unable to have a desired child. Preserving cancer patients' fertility fulfills the duty to repair what cancer and its treatment have broken, restoring the procreative capacity that most women find important to their identity, well-being, and happiness.¹⁴ A recent study of 240 female cancer survivors compared the psychosocial adjustment of 77 of the women who sought infertility treatment but remained childless to the rest of the sample.¹⁵ Perhaps unsurprisingly, these women reported significantly more infertility-related trauma symptoms, greater distress about infertility, and lower sexual and relationship satisfaction than the other cancer survivors, especially if they were childless.¹⁶ Oncofertility compassionately responds to the distress from infertility experienced by women like these and helps them realize their desire to have children.

Although fertility preservation adds to the reproductive options available to female cancer patients, one might ask why it is so important to many women to preserve the capacity to become a mother. Does the desire to preserve this option and the distress from losing it stem in part from a gender injustice? Some feminist scholars have worried that infertile women seek out ART in part because of the unjust expectation that all women will become mothers and the social stigma surrounding infertility.¹⁷ These scholars question the forces that drive so many women to endure the physical and emotional toll entailed in some forms of assisted reproduction. Freezing eggs involves first stimulating ovulation with daily hormone injections and retrieving eggs from the ovaries—a painful, risky, and costly process.

13. Adrienne Asch, *The Lessons of Oncofertility for Assisted Reproduction*, in ONCOFERTILITY: ETHICAL, LEGAL, SOCIAL, AND MEDICAL PERSPECTIVES, *supra* note 1, at 181, 184.

14. See Laurie Zoloth, Keynote Address at the Northwestern Oncofertility Consortium Annual Conference: The Duty of Repair in a Broken World: Ethical Questions After Five Years of Oncofertility Research (Sept. 12, 2011), available at <http://oncofertility.northwestern.edu/media/keynote-duty-repair-broken-world-ethical-questions-after-five-years-oncofertility-research>.

15. Andrea L. Canada & Leslie R. Schover, *The Psychosocial Impact of Interrupted Childbearing on Long-Term Female Cancer Survivors*, 21 PSYCHO-ONCOLOGY 134 (2012).

16. *Id.*

17. See generally BARBARA KATZ ROTHMAN, RECREATING MOTHERHOOD: IDEOLOGY AND TECHNOLOGY IN A PATRIARCHAL SOCIETY (1989). See also Angela Y. Davis, *Outcast Mothers and Surrogates: Racism and Reproductive Politics in the Nineties*, in AMERICAN FEMINIST THOUGHT AT CENTURY'S END 355, 360 (Linda S. Kauffman ed., 1993) (noting that "infertile women—or the wives/partners of infertile men—who are financially able to do so are increasingly expected to try everything," resulting in "an ideological compulsion" toward creating a child).

After this bodily trauma, the procedure may lead to further heart-break if it fails to produce a live baby. According to Katherine Franke, women are held to a standard of repronormativity that encompasses "the complex ways in which reproduction is incentivized and subsidized in ways that may bear upon the life choices women face."¹⁸ As I discuss in Parts III and IV, the government's incentivizing and subsidizing of reproduction does not apply equally to all women. Women of color in particular have been subject to policies designed to *deter* them from having children. Still, all women are affected by societal and cultural norms that associate the ideal female identity with motherhood. It is hard to disentangle the desperation for a child that leads some women to use ART from the pressure on them to meet this maternal standard.

The above-mentioned study of psychosocial distress in cancer survivors who seek infertility services also found that an unfulfilled desire to have a child was not associated with a higher level of general emotional distress or with poorer mental health. The authors concluded that "[i]n general, women in our sample had good overall psychological adjustment. . . . Thus, the distress appears to be limited to the fertility issue."¹⁹ This finding has been confirmed by several studies showing that "[p]sychological distress diminishes over the first year after breast cancer diagnosis, but sexual dysfunction, menopausal symptoms, and infertility-related distress remain severe and pervasive."²⁰ It is possible that the distress from infertility and stress in relationships these cancer survivors feel stem partly from the stigma they experience because they are unable to bear a child.

Just as infertility is stigmatized, so too is a woman's deliberate decision not to have children. In fact, it is considered downright unnatural. As Joan Callahan and I observed, "Our society does not think it is just fine for people to remain single and childless deliberately or for married people to remain childless deliberately. Infertility is constructed as a nearly unbearable tragedy; deliberate childlessness is constructed as nearly unimaginable selfishness."²¹ So if the option of egg freezing is available, some women may feel a duty to take advantage of it. When these social pressures are considered, it is harder to tell whether oncofertility only expands women's options and freedom,

18. Franke, *supra* note 9, at 184.

19. Canada & Schover, *supra* note 15, at 140.

20. Leslie R. Schover et al., *Sisters Peer Counseling in Reproductive Issues After Treatment (SPIRIT)*, 117 *CANCER* 4983, 4983 (2011).

21. Joan C. Callahan & Dorothy E. Roberts, *A Feminist Social Justice Approach to Reproduction-Assisting Technologies: A Case Study on the Limits of Liberal Theory*, 84 *KY. L.J.* 1197, 1225 (1996).

or whether it also contributes to the compulsion some women feel to be mothers.

The normative force of these social pressures is so strong and pervasive that there is a tacit assumption that all women cancer patients would want to preserve their fertility if the technology is perfected and available. Because the desire to have children is taken for granted, fertility preservation seems like an act of restoring nature, simply putting the woman back to normal. The underlying cultural expectation remains unnoticed. It may be easier, then, for technology to solve the problem in nature (infertility) than for society to tackle the problem in culture (the expectation that all women will be mothers).²²

Added to this expectation of motherhood is the exclusive notion of genetic parenthood.²³ Reproduction-assisting technologies do not simply permit infertile people to have children; they permit them to have children who are genetically related to them. If a cancer survivor decides to become a mother, she can fulfill this desire by adopting a child. She can also form a close bond with a child by helping to care for someone else's child.²⁴ Egg freezing is required only to ensure that women have children who are genetically related to them. This preference for biological ties over social ones unjustly gives greater value to genetic relatedness at a time when there are thousands of children available for adoption in the public foster care system and when many mothers would welcome assistance with caring for their children.²⁵ It falsely suggests that we are only capable of loving children who share our genes.

The argument to prioritize adoption over fertility preservation is complicated in the case of cancer survivors. Researchers have discovered that cancer survivors often lack information about adoption and face discrimination by adoption agencies.²⁶ Some agencies disqualify cancer survivors on the basis of vague standards for determining the

22. See Franke, *supra* note 9, at 185 & n.15.

23. See generally Dorothy E. Roberts, *The Genetic Tie*, 62 U. CHI. L. REV. 209 (1995).

24. For a discussion of the African-American practice of "other mothering," see PATRICIA HILL COLLINS, *BLACK FEMINIST THOUGHT: KNOWLEDGE, CONSCIOUSNESS, AND THE POLITICS OF EMPOWERMENT* 182, 192-93 (2d ed. 2000); CAROL B. STACK, *ALL OUR KIN: STRATEGIES FOR SURVIVAL IN A BLACK COMMUNITY* (1974).

25. For a critical discussion of the large and disproportionate numbers of African-American children in foster care, see DOROTHY ROBERTS, *SHATTERED BONDS: THE COLOR OF CHILD WELFARE* (2002). There, I argue that a goal of child welfare policy should be to reduce the numbers of children placed in foster care and in need of adoption by supporting families, rather than to fulfill the desires of adults who wish to adopt.

26. See generally Shauna L. Gardino et al., *Adoption After Cancer: Adoption Agency Attitudes and Perspectives on the Potential to Parent Post-Cancer*, in *ONCOFERTILITY: ETHICAL, LEGAL,*

"welfare of the child" that include medical conditions and lifestyle characteristics.²⁷ In the free-market ethos governing the adoption process, "[a]n individual with a clean medical history competing against a cancer survivor to adopt a child would arguably receive preferential treatment."²⁸

The tension between these competing gender-equity claims is especially acute in the ethics of preserving the future reproductive capacity of girls. Although ovarian tissue cryopreservation would expand a girl's future reproductive options, she might perceive the decision made by others to preserve her fertility as additional pressure to have a child. "[A] competent adult can consent to almost any legal medical procedure, including one that will permanently alter his or her reproductive capacities."²⁹ Minors, however, cannot decide for themselves. Parents are typically vested with the legal authority to make medical decisions for their minor children.³⁰

When parents consent to fertility-preserving surgery for their daughter, they may be giving her the same reproductive flexibility that a son who survives cancer would enjoy when deciding whether or not to have genetically related children. Their decision may save her from the trauma of discovering when she reaches childbearing age that she is incapable of bearing the child she desires. But her parents may also be intensifying the gendered expectations their daughter will confront. Now, not only will she experience the general norm to become a mother, but she will also feel the added expectation exerted by the existence of the eggs that have been extracted, matured, frozen, and stored at great expense just for this purpose. Some parents may even be motivated more by their own desire to have grandchildren than by their desire for their daughter to have greater reproductive autonomy. Is this any different, though, from the typical parents who encourage their daughters in subtle and not-so-subtle ways to become mothers? It can be argued that banked eggs exert no more undue pressure than a bank account that parents maintain as an incentive for their children to attend college.³¹

SOCIAL, AND MEDICAL PERSPECTIVES, *supra* note 1, at 153; Allison Rosen, *Third-Party Reproduction and Adoption in Cancer Patients*, 34 MONOGRAPHS 91 (2005).

27. Gardino et al., *supra* note 26, at 153.

28. *Id.* at 163.

29. Dolin et al., *supra* note 3, at 116.

30. See Barbara J. Stegmann, *Unique Ethical and Legal Implications of Fertility Preservation Research in the Pediatric Population*, 93 FERTILITY & STERILITY 1037 (2010) (discussing the potentially coercive nature of such decisions).

31. Lisa Campo-Engelstein, *Preserving the Right to Future Children: An Ethical Case Analysis*, 12 AM. J. BIOETHICS (forthcoming 2012).

On the one hand, we might compare failing to agree to an oncofertility procedure for a girl to actively sterilizing her, a procedure considered so extraordinary that it requires judicial approval.³² In both cases, it could be argued, the parents are depriving their daughter of the ability to have a child in the future. (Of course, sterilization is an affirmative act that destroys someone's reproductive capacity, which can be distinguished from not acting to restore reproductive capacity that has been destroyed by cancer.) On the other hand, we might be concerned that consenting to fertility-preserving surgery exerts undue interference with the child's own identity, making the surgery more comparable to sex assignment surgery performed on babies with ambiguous genitalia. Although sex assignment surgery is currently encouraged by many pediatricians, it has come under fire for foreclosing the child's right to an "open future."³³ (Of course, sex assignment surgery has a more constraining effect on a child's identity than does removing and preserving a girl's ovaries.) The opposite analogy could also be made: failing to preserve a girl's fertility forecloses an open future because it deprives the girl of the future ability to decide to bear children. Both preserving a daughter's fertility and failing to preserve it will have a tremendous impact on the girl's future.

Recognizing the influence of gender-biased norms on women's reproductive decision making, however, does not necessarily mean that fertility preservation is unethical because it reinforces gender bias. First, not all feminists agree that ART necessarily imposes patriarchal norms on women.³⁴ Indeed, assuming that cancer patients who preserve their fertility are bowing to patriarchal pressures treats women paternalistically. Respecting women's autonomy requires providing them with the means to fulfill their reproductive decisions and not to question the reasons for those decisions. The danger of government scrutiny of people's motives for their reproductive decisions overrides concern about reinforcing gender norms. As Tabitha Powledge wrote about sex selection, "I hate these technologies, but I do not want to see them legally regulated because, quite simply, I do not want to pro-

32. Dolin et al., *supra* note 3, at 120, 123–24.

33. *Id.* at 120.

34. See CHARIS THOMPSON, MAKING PARENTS: THE ONTOLOGICAL CHOREOGRAPHY OF REPRODUCTIVE TECHNOLOGIES 70 (2005) (noting that a new generation of feminist theorists see in ART "the potential to articulate new ways of embodying reproduction, some of which would disrupt conventional families and gender stereotypes" and that "they refused to read ARTs as simply signing and sealing preexisting oppressive social orders"). While some cancer survivors may use ART to challenge gender norms, the oncofertility field has not generally embraced this mission and typically helps cancer survivors form traditional marital families with genetically related children.

vide an opening wedge for legal regulation of reproduction in general.”³⁵

After all, cancer patients and others who are infertile should not have to sacrifice their procreative desires for the sake of ending discriminatory gender norms. Protection of individuals’ procreative liberty should prohibit state intervention in the choice to use oncofertility as long as that choice itself does not harm anyone.

Yet, a liberal approach to ART dedicated solely to protecting individual choices from state interference, but not from market and social inequities, fails to address major impediments to women’s freedom under the neoliberal conditions that exist today. As the members of the Alliance for Humane Biotechnology observe, “The need for securing a woman’s right to choose that found moorings in a liberal state experimenting with health and welfare programs plays out quite differently in the techno-libertarian context where radical individualism denies the interconnectedness of human relations.”³⁶ Even the liberal state to which the authors refer denied the right to public funding for abortion services, leaving some women who could not afford this form of medical care unable to choose to terminate an unwanted pregnancy.³⁷ In recent decades the state has drastically slashed social programs, including those that assist struggling mothers, while promoting the free-market conditions conducive to capital accumulation.³⁸ Critical to this process of state restructuring is the transfer of services from the welfare state to the private realms of market, family, and individual; the reliance on individualized technological solutions for social wrongs; and the neglect of people who cannot succeed in the free market.³⁹ The goal of public policy should be to protect and support a woman’s decision to have a child, including the provision of resources

35. Tabitha M. Powledge, *Unnatural Selection: On Choosing Children's Sex, in THE CUSTOM-MADE CHILD? WOMEN-CENTERED PERSPECTIVES* 193, 197 (Helen B. Holmes et al. eds., 1981); see also GENERATIONS AHEAD, POSITION STATEMENT ON LEGISLATION BANNING ABORTION FOR REASONS OF SEX OR RACE, available at http://www.generations-ahead.org/files-for-download/success-stories/ps_legislation1.pdf (“Our real challenge is to change the context in which sex selection and racial disparities develop, addressing gender and racial equality issues while protecting the right of all women to make the best reproductive decisions for themselves and their families.”).

36. Tina Stevens et al., *Finding the Active Voice: The Challenge of Developing Prochoice Regulation of ARTs*, GENE WATCH, June–July 2011, at 23, 23.

37. ROBERTS, *supra* note 7, at 229–32; see also *Harris v. McRae*, 448 U.S. 297 (1980) (upholding the constitutionality of public funding restrictions for medically necessary abortions.)

38. See generally NOAM CHOMSKY, *PROFIT OVER PEOPLE: NEOLIBERALISM AND GLOBAL ORDER* (1999); DAVID HARVEY, *A BRIEF HISTORY OF NEOLIBERALISM* (2005).

39. See DOROTHY ROBERTS, *FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY* 300–02 (2011); LOIC WACQUANT, *PUNISHING THE POOR: THE NEOLIBERAL GOVERNMENT OF SOCIAL INSECURITY* (2009).

needed for care giving, while eliminating the gender-biased stigma directed at women who do not have children.

Second, some of the concerns underlying feminist objections to certain ART do not apply to oncofertility. One reason for the infertility of well-educated, high-income women is their postponement of childbearing in order to pursue a career. The root cause of these women's infertility is not biological; rather, it is a workplace that makes it extremely difficult for women to combine employment and childbearing.⁴⁰ Using ART to treat infertility caused by postponed childbearing, some argue, "could divert attention away from the social structures that pressure women to delay child-bearing in the first place."⁴¹ By freezing their eggs, these women can bypass this social problem through technological intervention without eliminating the structural unfairness that forced them to choose between a career and motherhood. But cancer patients who become infertile are not suffering from a discriminatory system that should be fixed. Infertility caused by cancer does not result from unequal social structure in the same way as infertility caused by women's careers. In this respect, the distinction between medical and structural infertility noted in the introduction is relevant to the ethics of oncofertility.

At the same time, there may not be such a neat distinction between medical and structural infertility in all cases. An article on the psychosocial impact of infertility on female cancer survivors begins by noting how the two types of infertility may be intertwined:

More women are delaying pregnancy until their thirties, only to have cancer interrupt their life plans. By age 39, one in 51 women will be diagnosed with an invasive cancer. Treatment for cancers most common in premenopausal women often decreases fertility or leads to permanent ovarian failure.⁴²

In other words, some cancer patients may be childless and desire to become pregnant for the first time during treatment because they postponed childbearing until an age when they have a greater risk of getting cancer. Freezing these patients' eggs is not really a distinctive kind of fertility preservation—prior to cancer treatment these women had the same reduced fertility as other women their age who do not have cancer. One might see oncofertility in these cases as deflecting attention from the underlying social reasons that led the patients to

40. See generally JOAN WILLIAMS, *UNBENDING GENDER: WHY FAMILY AND WORK CONFLICT AND WHAT TO DO ABOUT IT* (2000).

41. Asch, *supra* note 13, at 184; see also Michele Goodwin, *Assisted Reproductive Technology and the Double Bind: The Illusory Choice of Motherhood*, 9 J. GENDER, RACE & JUST. 1 (2005).

42. Canada & Schover, *supra* note 15, at 134 (footnotes omitted).

put off pregnancy until an age when they were more vulnerable to both cancer and infertility.

Another set of concerns that has less relevance to oncofertility has to do with the commodification of women's bodies and reproductive labor that results from egg donation and surrogacy.⁴³ The sale of eggs and renting of wombs create a market in women's reproductive labor that exploits and devalues the less privileged women who provide procreative goods and services to those more privileged. According to Kathy Sloan, a human rights advocate specializing in global feminism, the troubling issues raised by surrogacy include:

the ethical and practical ramifications of the further commodification of women's bodies (beyond universal sexual commodification); exploitation of poor and low income women; implications for women's reproductive rights if embryos become legally detined; rights of the children produced to information regarding their genetic history and any siblings they may have who are the offspring of the donor parents; prevention and prosecution of fraud by surrogacy companies; and the moral and ethical consequences of transforming a normal biological function of a woman's body into a commercial contract.⁴⁴

These harms of commercialized third-party reproduction do not occur when women preserve their own eggs for future fertilization and implantation unless they hire a surrogate to gestate the baby. Although cancer patients must pay medical expenses and storage fees, there is no commercial exchange for their eggs or wombs.

Oncofertility is not immune to the commercial pressures that govern ART, however, and some dangers highlighted by feminist critics of ART apply. One of the main concerns for women who supply eggs for ART is the risk to their health caused by the procedures required for egg retrieval. The multiple injections of hormones to stimulate their ovaries to produce eggs and surgeries to harvest these eggs have been associated with short- and long-term injuries, including ovarian hyperstimulation syndrome, ovarian cysts, infection, bleeding, kidney failure, stroke, cancer, and infertility.⁴⁵ Despite evidence of medical

43. See generally MARGARET JANE RADIN, *CONTESTED COMMODITIES* (1996); FRANCE WINDANCE TWINE, *OUTSOURCING THE WOMB: RACE, CLASS, AND GESTATIONAL SURROGACY IN A GLOBAL MARKET* (2011); Debra Satz, *Markets in Women's Reproductive Labor*, 21 *PHIL. & PUB. AFF.* 107 (1992).

44. Kathy Sloan, *Abuses of Women's Human Rights in Third Party Reproduction*, *GENE WATCH*, June-July 2011, at 20, 21.

45. See Jaime F. Avecillas et al., *Ovarian Hyperstimulation Syndrome*, 20 *CRITICAL CARE CLINICS* 679 (2004); Joseph G. Whelan III & Nikos F. Vlahos, *The Ovarian Hyperstimulation Syndrome*, 73 *FERTILITY & STERILITY* 883 (2000); Kenneth H.H. Wong, *Ovarian Hyperstimulation Syndrome*, in *REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY: INTEGRATING MODERN*

risks, there are no registries or studies that track the long-term health outcomes of egg donors, nor any state or federal regulation requiring the fertility industry to investigate and report these risks, owing in part to resistance from the multibillion dollar fertility business.⁴⁶ These health risks exist whether a woman has her eggs harvested for pay or to preserve her own fertility (depending on how many eggs are harvested), and she should have the information needed to weigh these risks against the potential benefits of future childbearing.⁴⁷ Given the ordinary health risks of egg harvesting, combined with additional interference with their cancer treatment, some women may prefer a less hazardous alternative, such as adoption or remaining childless.

One way out of the gender-equity paradox described above is to implement procedures to reduce the pressures female cancer patients feel to have genetically related children. Advocates who are working to ensure that oncologists inform their patients about fertility preservation should also work to ensure that women and girls are not pressured into freezing their eggs. Rather than assume that fertility preservation makes all women patients better off, women should be able to assess the risks of the procedure and alternatives to bearing a child, such as adopting a child, being a fulfilled woman who is childless, or helping to mother other women's children. Recognizing the gendered expectations weighing on women makes fully informed consent, safeguards against physician conflicts of interest, and other protections of patient autonomy especially important. Oncofertility programs should also include efforts to remove barriers to adoption faced by cancer survivors.

Are these protections of patient autonomy enough? The focus of traditional bioethics on patient autonomy in the clinical context tends to neglect the social context of patient decision making and equally important questions of social equality and justice.⁴⁸ In evaluating the best use of public investment, we might want to promote adoption by discouraging fertility preservation. Finding no support for the necessity of genetic parenting, Carolyn McLeod argues, "To offset the bias

CLINICAL AND LABORATORY PRACTICE 711 (Douglas T. Carrell & C. Matthew Peterson, eds. 2010).

46. Catherine Elton, *As Egg Donations Mount, So Do Health Concerns*, TIME (Mar., 31, 2009), available at <http://www.time.com/time/health/article/0,8599,1888459,00.html>.

47. See Sonia M. Suter, *Giving In to Baby Markets: Regulation Without Prohibition*, 16 MICH. J. GENDER & L. 217, 242–51 (2009) (describing the risks entailed in egg donation and proposing enhanced informed consent requirements).

48. See, e.g., TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (6th ed. 2009).

that our society has toward biologic parenting, perhaps we ought to encourage non-biologic parenting for infertile cancer survivors, for infertile people in general, or for everyone for that matter.”⁴⁹ McLeod points to psychological studies indicating that infertile people who adopt children have levels of well-being similar to those who succeed with fertility treatments.⁵⁰ The just allocation of public resources may warrant their investment in adoption for cancer survivors rather than in preserving their fertility. This investment approach might take the form of refusing to subsidize fertility preservation procedures either through state funding or insurance mandates. But is it just to deny these procedures to the majority of women when affluent women who can afford it have access to them? The next Part will address that question.

III. ECONOMIC INEQUALITY AND ACCESS TO ONCOFERTILITY

Harvesting and storing eggs is expensive. The average facility charge alone for ovarian tissue cryopreservation has been approximately \$30,000.⁵¹ The average cost of an IVF cycle is approximately \$12,500, and the average cost per live birth is more than \$40,000.⁵² So poverty and low incomes, combined with other social barriers, keep many women from using fertility preservation services. As Mary Lyndon Shanley and Adrienne Asch observe, “Poorer women and those who lack health insurance are less likely to go to a doctor for fertility assistance, and race, education level attained, marital or cohabitation status, and socioeconomic status all affect access to fertility services.”⁵³ At present, “insurance coverage for fertility preservation is not mandated nationally or in any state, making it unaffordable for the majority of eligible women.”⁵⁴ Some oncofertility programs are lobbying state legislatures to require private insurance companies to include fertility preservation in their coverage.⁵⁵

49. Carolyn McLeod, *Morally Justifying Oncofertility Research*, in *ONCOFERTILITY: ETHICAL, LEGAL, SOCIAL, AND MEDICAL PERSPECTIVES*, *supra* note 1, at 187, 191 (citation omitted).

50. *Id.*

51. Shauna L. Gardino et al., *Anticipating Ovarian Tissue Cryopreservation in the Health-Care Marketplace: A Willingness to Pay Assessment*, in *ONCOFERTILITY: ETHICAL, LEGAL, SOCIAL, AND MEDICAL PERSPECTIVES*, *supra* note 1, at 363, 365.

52. Georgina M. Chambers et al., *The Economic Impact of Assisted Reproductive Technology: A Review of Selected Developed Countries*, 91 *FERTILITY & STERILITY* 2281, 2291 (2009).

53. Mary Lyndon Shanley & Adrienne Asch, *Involuntary Childlessness, Reproductive Technology, and Social Justice: The Medical Mask of Social Illness*, 34 *SIGNS* 851, 856 (2009).

54. Canada & Schover, *supra* note 15, at 135 (footnotes omitted).

55. See Lisa Campo-Engelstein, *For the Sake of Consistency and Fairness: Why Insurance Companies Should Cover Fertility Preservation Treatment for Iatrogenic Infertility*, in *ONCOFERTILITY: ETHICAL, LEGAL, SOCIAL, AND MEDICAL PERSPECTIVES*, *supra* note 1, at 381, 385.

Will subsidizing fertility preservation help to reduce economic disparities in reproductive health by increasing access to these procedures, or will it privilege those women who are already the most economically advantaged? The unequal distribution of wealth in our society prevents less affluent people from buying countless goods and services that wealthy people can afford. One might argue that, while these financial barriers are unfortunate, they do not justify interfering with those fortunate enough to have access to oncofertility. Nor does the right to use ART necessarily entail the governmental obligation to provide access to such technology. Medical innovations often increase inequality because wealthy people start from an advantaged position and are better able to make use of them.⁵⁶ Yet this is no reason to stifle medical progress and access to its benefits by those who can afford it.

But there is a compelling counterargument that the social harm that stems from confining fertility preservation in the hands of wealthy people is reason to ensure equalized access to oncofertility. Procreation holds a special status central to "personal identity, to dignity, and to the meaning of one's life"⁵⁷ and recognized by the Supreme Court of the United States as "one of the basic civil rights of man."⁵⁸ Procreative liberty's importance to human dignity is a compelling reason to guarantee the equal distribution of procreative resources in society. Conversely, privileging procreation by social elites while devaluing procreation by socially disadvantaged groups historically has been a chief form of state oppression.⁵⁹ Wealth, like gender, should not determine which cancer survivors are able to have a child.

Proposals to mandate insurance coverage provide only a limited financial resource, however, one that will do little to bridge the huge lacuna between the ART available to rich and poor women. Indeed, subsidizing oncofertility for people who have private health insurance without ensuring equal access to low-income and poor patients will privilege those who are already better off, only increasing economic disparities. Millions of women are not covered by private health insurance and rely on Medicaid to pay for their medical care.⁶⁰ Medi-

56. Bruce G. Link & Jo C. Phelan, *Fundamental Sources of Health Inequalities*, in *POLICY CHALLENGES IN MODERN HEALTH CARE* 71, 80 (David Mechanic et al. eds., 2005).

57. JOHN A. ROBERTSON, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* 24 (1994).

58. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

59. EDWIN BLACK, *WAR AGAINST THE WEAK: EUGENICS AND AMERICA'S CAMPAIGN TO CREATE A MASTER RACE* (2003); DANIEL J. KEVLES, *IN THE NAME OF EUGENICS* (1995).

60. *By Population*, MEDICAID.GOV. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/By-Population.html> ("Medicaid provides health coverage to 11 million

caid covers only medically necessary procedures,⁶¹ and infertility treatment is considered elective. So while women who are covered by private insurance, probably through their employers, would have access to fertility preservation, poor women who rely on Medicaid would not.

Even if the state were to provide minimal subsidies for fertility preservation by low-income and poor women, wealthy women would have access to more advanced technologies and would be able to pay for additional services. If the state or insurance companies pay for one round of IVF, for example, the affluent can pay for several. Wealthier women can also afford genetic testing, sex selection, and even so-called "cosmetic" genetic screening to enable them not only to have a genetically related child, but also to have a child with preferred genetic traits.⁶² Policies that increase access to fertility preservation raise the ethical question of how much equality the public is willing to support.

Expanding state subsidies for ART to close the economic access gap, in turn, raises the question of whether the just distribution of public resources warrants such a large investment in technologically enhanced fertility. Can the government ethically channel millions of health care dollars to enable cancer survivors to have genetically related children rather than spending similar amounts on programs that would provide more extensive benefits to infertile people in particular and public health in general? Research designed to reduce infertility and the universal provision of basic health care are examples of expenditures that would help a far broader range of people than high-tech fertility preservation.⁶³ Ideally, these objectives would have high priority in a reformed U.S. health care system. The public would then

non-elderly low-income parents, other caretaker relatives, pregnant women, and other non-disabled adults.").

61. KAISER FAMILY FOUND. & GEORGE WASHINGTON UNIV. MED. CTR. SCH. OF PUB. HEALTH & HEALTH SERVS., *STATE MEDICAID COVERAGE OF FAMILY PLANNING SERVICES: SUMMARY OF STATE FINDINGS*, at tbl.4 (2009), available at <http://www.kff.org/womenshealth/8015.cfm>.

62. See generally DEBORA L. SPAR, *THE BABY BUSINESS: HOW MONEY, SCIENCE, AND POLITICS DRIVE THE COMMERCE OF CONCEPTION* (2006); Michael J. Sandel, *The Case Against Perfection: What's Wrong with Designer Children, Bionic Athletes, and Genetic Engineering*, ATLANTIC MONTHLY, Apr. 2004, at 51.

63. See Link & Phelan, *supra* note 56, at 80 ("When we create interventions that are expensive and difficult to distribute broadly, we create health disparities."); see also Elizabeth Heitman, *Infertility as a Public Health Problem: Why Assisted Reproductive Technologies Are Not the Answer*, STAN. L. & POL'Y REV., no. 2, 1995, at 89, 96 ("By promoting research and education on the causes of infertility, and providing programs to modify or prevent behaviors that increase infertility-causing disease, the need for infertility treatment could be reduced and the medical services provided more effectively."). Recognizing the persistence of health inequities despite

have to evaluate the priority to give oncofertility, as well as other expensive high-tech procedures benefitting relatively few patients, in a system providing universal health care.

IV. RACIAL INEQUALITY AND WOMEN OF COLOR

A related question is whether extending fertility preservation to women of color would help to reduce racial gaps in reproductive health or reinforce racial assumptions underlying high-tech reproduction and a misplaced faith in technological solutions to social problems. There is a strong case for efforts to increase fertility preservation among women of color because the use of ART is currently marked by stark racial disparities.⁶⁴ Although black women are more likely to be infertile than white women, they are less likely to use high-tech reproduction-assisting technologies and have poorer success rates when they do.⁶⁵ Indeed, according to a 2010 *Fertility and Sterility* report, infertility among black women in the United States has increased in recent years while the rate among white women has declined.⁶⁶ Although black and Latina women may be less likely to seek these services for cultural reasons, they also confront barriers because it is “more difficult to get an appointment, to take time off from work, and to pay for treatment.”⁶⁷ In addition, stereotypes of maternal unfitness and repressive policies aimed at deterring black and Latina women from having children have historically devalued their decisions to become mothers.⁶⁸ Images of the promise and successes of high-tech reproduction usually depict white babies; when black children are mentioned in news stories about ART, they are usually featured as the products of mistakes made by fertility clinics.⁶⁹ The devaluation of minority childbearing has steered public policies and

improvements in medical care. Phelan and Link argue that we should prioritize health interventions whose benefits do not depend on the personal resources of individuals.

64. CAHN, *supra* note 4, at 141–42. For an argument to extend access to ART in the global context, see Amanda Fleetwood & Lisa Campo-Engelstein, *The Impact of Infertility: Why ART Should Be a Higher Priority for Women in the Global South*, in *ONCOFERTILITY: ETHICAL, LEGAL, SOCIAL, AND MEDICAL PERSPECTIVES*, *supra* note 1, at 237.

65. Samantha F. Butts & David B. Seifer, *Racial and Ethnic Differences in Reproductive Potential Across the Life Cycle*, 93 *FERTILITY & STERILITY* 681 (2010).

66. David B. Seifer et al., *Trends of Racial Disparities in Assisted Reproductive Technologies Outcomes in Black Women Compared with White Women: Society for Assisted Reproductive Technology 1999 and 2000 vs. 2004–2006*, 93 *FERTILITY & STERILITY* 626 (2010).

67. Stacey A. Missmer et al., *Cultural Factors Contributing to Health Care Disparities Among Patients with Infertility in Midwestern United States*, 95 *FERTILITY & STERILITY* 1943, 1943 (2011).

68. See generally ROBERTS, *supra* note 7; ELENA R. GUTIÉRREZ, *FERTILE MATTERS: THE POLITICS OF MEXICAN-ORIGIN WOMEN'S REPRODUCTION* (2008).

69. ROBERTS, *supra* note 7, at 250–52.

clinical decision making away from making ART equally accessible to women of color.⁷⁰ Thus, the intersection of gender, class, and race in the lives of these women creates a social context that imposes especially formidable barriers to fertility preservation.

There is evidence that many women of color wish to use ART but are prevented by impediments to access. Studies have found that use of reproduction-assisting technologies by African-American women increases dramatically when these barriers are removed.⁷¹ For example, a team of federal researchers discovered that African-American women's use of ART services increased fourfold in the military health care system where access to medical care is widely available compared to the general ART population in the United States.⁷²

Yet racial disparities persist even with better insurance coverage of ART. Insurance helps to reduce the racial gap, but it is not enough to close it. One study found that "[e]ven in states with mandated insurance coverage, the individuals who access IVF services tend to be predominantly Caucasian, highly educated, and wealthy."⁷³ A 2006 study similarly concluded, "[W]e find no evidence that these mandates have mitigated the disparities in access to treatment by race, ethnicity, or SES [socioeconomic status] (as proxied by education)."⁷⁴ The authors noted that further research is needed to explore why mandates do not reduce racial disparities in access. A likely reason is that highly educated, affluent white women are the group most likely to have private health insurance. Women of color are more likely to rely on Medicaid for their health care or be uninsured.⁷⁵ Far from receiving

70. *Id.*; Nanette R. Elster, *ART for the Masses?: Racial and Ethnic Inequality in Assisted Reproductive Technologies*, 9 DEPAUL J. HEALTH CARE L. 719 (2005); Lisa C. Ikemoto, *The Infertile, The Too Fertile, and The Dysfertile*, 47 HASTINGS L.J. 1007 (1996).

71. Eve C. Feinberg et al., *Comparison of Assisted Reproductive Technology Utilization and Outcomes Between Caucasian and African American Patients in an Equal-Access-to-Care Setting*, 85 FERTILITY & STERILITY 888 (2006) (finding an increase in African-American but not Latina women's use of ART); Desireé M. McCarthy-Keith et al., *Will Decreasing Assisted Reproductive Technology Costs Improve Utilization and Outcomes Among Minority Women?*, 94 FERTILITY & STERILITY 2587 (2010) (same).

72. Feinberg et al., *supra* note 71, at 893.

73. Victor Y. Fujimoto et al., *Proceedings from the Conference on Reproductive Problems in Women of Color*, 94 FERTILITY & STERILITY 7, 7 (2010).

74. Marianne Bitler & Lucie Schmidt, *Health Disparities and Infertility: Impacts of State-Level Insurance Mandates*, 85 FERTILITY & STERILITY 858, 864 (2006).

75. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 25 (2010), available at <http://www.census.gov/prod/2010pubs/p60-238.pdf>; James B. Kirby & Toshiko Kaneda, *Unhealthy and Uninsured: Exploring Racial Differences in Health and Health Insurance Coverage Using a Life Table Approach*, 47 DEMOGRAPHY 1035 (2010).

subsidies to increase their fertility, these women are subject to government policies deterring them from having children.

Another possible reason for the persistent racial gap in ART use is bias against patients of color, which leads physicians to devalue these patients' childbearing or the importance of giving them information about fertility preservation.⁷⁶ In a study of doctor–patient communication about oncofertility, sociologist Karrie Ann Snyder found that even in a sample of middle-class women with private insurance African-American women were far less likely to discuss fertility preservation and more likely to have superficial discussions with their doctors than white women.⁷⁷

Equalizing access is also insufficient because racial disparities plague the outcomes of infertility treatment. As troubling as the gap in the use of ART is the finding that African-American women have significantly lower live-birth rates after IVF than white women.⁷⁸ Several studies found “significant reductions (25%–38%) in African American live-birth rates after IVF when compared with Caucasian cohorts.”⁷⁹ As a team of researchers concluded, “Improved access may not translate into improved outcomes in some ethnic groups.”⁸⁰

The racial disparity in live births probably stems from the staggering racial inequities that exist in overall health and access to health care in the United States.⁸¹ In addition to their greater reliance on Medicaid,

76. Dorothy E. Roberts, *Reconstructing the Patient: Starting with Women of Color*, in *FEMINISM & BIOETHICS: BEYOND REPRODUCTION* 116 (Susan M. Wolf ed., 1996). On racial bias in medical care, see JOHN HOHERMAN, *BLACK AND BLUE: THE ORIGINS AND CONSEQUENCES OF MEDICAL RACISM* (2012); HARRIET WASHINGTON, *MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT* (2006).

77. Karrie Ann Snyder, Talk presented at Northwestern Oncofertility Consortium Annual Conference: The Patient-Physician Interface: How Breast Cancer Patients Navigate Fertility Concerns and Treatment Options (Sept. 12, 2011), available at <http://oncofertility.northwestern.edu/media/patient-physician-interface-how-breast-cancer-patients-navigate-fertility-concerns-and-treat-0>; see also CAHN, *supra* note 4, at 142 (discussing reasons why African-American women may be uncomfortable discussing infertility with their doctors); Arthur L. Greil et al., *Race-Ethnicity and Medical Services for Infertility: Stratified Reproduction in a Population-Based Sample of U.S. Women*, 52 J. HEALTH & SOC. BEHAV. 493 (2011) (discussing a study investigating attitudinal, social, and interpersonal pathways connecting race-ethnicity and medical services for infertility).

78. Butts & Seifer, *supra* note 65; Victor Y. Fujimoto et al., *Racial and Ethnic Disparities in Assisted Reproductive Technology Outcomes in the United States*, 93 FERTILITY & STERILITY 382 (2010); McCarthy-Keith et al., *supra* note 71; Seifer et al., *supra* note 66.

79. Fujimoto et al., *supra* note 73, at 8.

80. McCarthy-Keith et al., *supra* note 71, at 2587.

81. See generally DONALD A. BARR, *HEALTH DISPARITIES IN THE UNITED STATES: SOCIAL CLASS, RACE, ETHNICITY, AND HEALTH* (2008); INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (Brian D. Smedley et al. eds., 2003).

which limits the availability of ART, women of color are more likely to be in poor health and to receive lower quality health care, including cancer treatment.⁸² As one article summarized:

Compared with Caucasian women, African-American women are less likely to be diagnosed at an early age, have higher mortality rates, and are more likely to be diagnosed before age 40 years. African-American breast cancer survivors [less than] 50 years report poorer physical quality of life than white survivors.⁸³

Although black women in Chicago are slightly less likely than white women to get breast cancer, black women are sixty-eight percent more likely to die from it.⁸⁴ The reason is that most black women in Chicago live in segregated neighborhoods where they do not have access to the cancer detection and care or the social determinants of good health available to white women living in the city.⁸⁵ A staggering death disparity exists in reproductive health as well. A 2010 Amnesty International report, *Deadly Delivery*, stated that “African-American women . . . are nearly four times more likely to die of pregnancy-related complications than white women.”⁸⁶

The racial gap in actual outcomes despite increased use of ART raises troubling questions about the ethics of oncofertility considered in its social context. Concentrating efforts on increasing insurance coverage for fertility preservation, rather than on providing basic universal health care for everyone, privileges white women who currently have far better access to high-quality medical care. This reality accentuates the questions of just distribution of public resources asked in Part III: should we devote state funds to high-tech fertility preservation when many people do not have access to the basic health care needed to bear healthy children and enjoy good health as adults? Adding the particular experiences and needs of women of color reveals that this question involves not only the inability to afford oncofertility, but also race-based impediments to good health and high-quality health care.

Think also about the higher rates of infertility among women of color. It would be more effective to address this need by improving

82. ELEANOR HINTON HOYT & HILARY BEARD, *HEALTH FIRST: THE BLACK WOMAN'S WELLNESS GUIDE* 111-235 (2012).

83. Schover et al., *supra* note 20, at 4983.

84. Jocelyn Hirschman et al., *The Black/White Disparity in Breast Cancer Mortality: The Example of Chicago*, 18 *CANCER CAUSES & CONTROL* 323, 325-26 (2007).

85. See David Ansell et al., *A Community Effort to Reduce the Black/White Breast Cancer Mortality Disparity in Chicago*, 20 *CANCER CAUSES & CONTROL* 1681, 1686 (2009); Shane Tritsch, *The Deadly Difference*, CHICAGO, Oct. 2007, at 120.

86. AMNESTY INT'L, *DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA* 1 (2010).

the basic conditions that lead to their infertility, such as occupational and environmental hazards, diseases, abysmal reproductive health care in prisons, and complications following childbirth or abortion.⁸⁷ Black and Latina women are also disproportionately forced to delay childbearing by long prison sentences that keep them behind bars during their most fertile years.⁸⁸ The focus on infertility caused by delayed careers caters primarily to middle-class white women and obscures the causes of infertility more common among women of color.⁸⁹ Moreover, women of color are less able to afford to technologically bypass the structural unfairness in the workplace that pressures some women to delay childbearing. The luxury of high-tech fertility preservation takes the place of widespread reforms that would increase all women's employment options. Relying on expensive interventions such as egg freezing to resolve the tensions between child raising and work keeps women from joining together to demand radical change in the sexual division of labor. As I noted in *Killing the Black Body*:

This reliance on high-tech intervention rather than improving basic health and workplace conditions hurts not only Black women but all women and, ultimately, all of our society. We would all benefit from a health policy that redirected the billions of dollars currently spent on fertility treatment toward eradicating the causes of infertility. We would all benefit from a view of family that valued loving relationships, however created, rather than genes traded on the market. We would all benefit from a work world that appreciated mothers' care for children.⁹⁰

This ethical critique of fertility preservation competes with ethical reasons to enable women cancer survivors to restore their fertility destroyed by disease and to make this technology widely available. Its social context of gender, class, and race inequities shows that, at a minimum, advocates for state support for oncofertility research and services should work toward equalizing general health and access to high-quality medical care along with access to fertility preservation. It is also critical to democratize the public evaluation of these priorities to include the views of poor women and women of color.

87. Heitman, *supra* note 63; Human Rights Program at Justice Now, *Prisons as a Tool of Reproductive Oppression*, 5 STAN. J. C.R. & C.L. 309, 325–29 (2009).

88. Human Rights Program at Justice Now, *supra* note 87, at 329–34.

89. Heitman, *supra* note 63, at 89 (arguing that “incomplete conceptual definitions skew the epidemiological data on infertility in ways that exaggerate the proportion of infertile couples whom assisted reproductive technologies might help”).

90. ROBERTS, *supra* note 7, at 292.

V. CONCLUSION

Ethical consideration of oncofertility must place this technological innovation in its social context. This Article shows that attending to the gender, class, and race inequities that influence women's reproductive health and decision making highlights several paradoxical tensions that complicate the ethics of oncofertility. There are compelling ethical reasons to restore women cancer survivors' capacity to have a child, more easily preserved for men, and for the public to support wide access to this restoration. Yet an investigation of the underlying structural injustices that place many women in conditions of infertility, poor health, and inadequate access to medical care raises questions about whether this would be a just distribution of public resources. We must consider whether eradicating these unjust conditions requires focusing on systemic change rather than expensive technological interventions. At a minimum, advocates for oncofertility must ensure that patients receive full information about the risks of, and alternatives to, egg freezing and support efforts to implement universal and equal access to high-quality health care, as well as the democratic governance of new human biotechnologies. Otherwise, this form of high-tech reproduction can intensify inequalities by privileging people who are already the most economically and socially advantaged even if insurance coverage extends its reach.